DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:	2. STATE:
2000 — 15	MS

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
~~October 1, 2000~~ October 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.272

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 10,000,000
b. FFY 2002 $ 10,000,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 4.19-A, Page 15

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Att. 4.19-A, Page 15

10. SUBJECT OF AMENDMENT: This State Plan Amendment allows state operated hospitals to be reimbursed an amount up to the upper payment limit.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[signature]

13. TYPED NAME:
Nica Lewis-Payton

14. TITLE:
Executive Director

15. DATE SUBMITTED:
December 26, 2000

16. RETURN TO:
Nica Lewis-Payton, Executive Director
Division of Medicaid
Attn: Rose Compere
239 North Lamar Street, Suite 801
Jackson, MS 39201-1399

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
December 29, 2000

18. DATE APPROVED:
March 15, 2000

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:
[signature]

21. TYPED NAME:
Eugene A. Crasser

22. TITLE:
Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:
State agency authorized "pen and ink" change of effective date from October 15, 2000, to October 1, 2000.

FORM HCFA-179 (07-92)

Instructions on Back

Capital Cost Component, the Medicaid Prospective Educational Cost Component, and the Medicaid Prospective Operating Cost Component. Amount allowed by appeals or adjustments will be added to or subtracted from this total. This rate shall be referred to as the Medicaid Prospective Rate.

F. State operated facilities may be reimbursed subject to the upper payment limit. Payments will be made bi-monthly in lump sums not to exceed the Medicare upper payment limit. In order to qualify for this program, the hospital must be a state owned hospital. For each state operated hospital, payments will be made for the difference in what Medicaid has paid for a Medicaid service and what Medicare would have paid for the same service in a period of time.

VI Plan Implementation

A. Payments under this plan will be effective for services rendered July 1, 1981 and thereafter.

B. The Division of Medicaid will provide an opportunity for interested members of the public to review and comment on the rate methodology before it is implemented. This will be accomplished by publishing in newspapers of widest circulation in each city in Mississippi with a population of 50,000 or more prior to implementing the rate methodology. A period of thirty (30) days will be allowed for comment. The Division of Medicaid will notify the administrator of each hospital of the prospective rate for their hospital.

C. The Division of Medicaid shall maintain any comments received on the plan, subsequent changes to the plan, or rates for a period of five (5) years from the date of receipt.

VII Application of Sanctions

A. Sanctions may be imposed by the Division of Medicaid against a provider for any one of the following reasons:

1. Failure to disclose or make available to the Division of Medicaid, or its authorized agent, any records of services provided to Medicaid recipients and records of payment made therefor.